



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PINE CREEK MEDICAL CENTER
9032 HARRY HINES BLVD
DALLAS TX 75235

Respondent Name

TPCIGA FOR LUMBERMENS MUTUAL CASUALTY CO

Carrier's Austin Representative Box

Box Number 50

MFDR Tracking Number

M4-10-3758-02

MFDR Date Received

April 22, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier failed to notify HCP of any contractual agreement, therefore, we request that this claim be paid in accordance with TDI-DWC Medical Fee Guidelines."

Amount in Dispute: \$19,811.37

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Enclosed please find a copy of the EOBs and the informal/voluntary network contract that was utilized."

Response Submitted by: Downs • Stanford, P.C. and Thornton, Biechlin, Segrato, Reynolds & Guerra, L.C.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
October 20, 2009	Outpatient Hospital Services	\$19,811.37	\$19,407.74

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated November 24, 2009

- 670-007 – REIMBURSEMENT IS BASED ON THE PROVIDER'S REQUEST FOR SEPARATE PAYMENT CONSIDERATION FOR IMPLANTABLE DEVICES.
- 859 – PLEASE PROVIDE A VALID NDC, CPT, HCPCS CODE, CHARGEMASTER CODE, AND/OR QUANTITY, ALONG WITH AN INVOICE IF APPLICABLE FOR APPROPRIATE REIMBURSEMENT \$0.00

- 95 – PLAN PROCEDURES NOT FOLLOWED.
- 989-101 – THIS BILL WAS REVIEWED IN ACCORDANCE WITH YOUR FEE FOR SERVICE CONTRACT WITH FIRST HEALTH.

Explanation of benefits dated December 9, 2009

- 080 – REVIEW OF THIS BILL HAS RESULTED IN AN ADJUSTED REIMBURSEMENT OF \$2,700.00
- 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT.
- 670-007 – REIMBURSEMENT IS BASED ON THE PROVIDER'S REQUEST FOR SEPARATE PAYMENT CONSIDERATION FOR IMPLANTABLE DEVICES.
- 859 – PLEASE PROVIDE A VALID NDC, CPT, HCPCS CODE, CHARGEMASTER CODE, AND/OR QUANTITY, ALONG WITH AN INVOICE IF APPLICABLE FOR APPROPRIATE REIMBURSEMENT \$0.00
- 95 – PLAN PROCEDURES NOT FOLLOWED.
- 989-101 – THIS BILL WAS REVIEWED IN ACCORDANCE WITH YOUR FEE FOR SERVICE CONTRACT WITH FIRST HEALTH.
- W1 – Workers Compensation State Fee Schedule Adjustment
- W1 – Workers Compensation State Fee Schedule Adjustment \$2,700.00

Explanation of benefits dated February 4, 2010

- 670-007 – REIMBURSEMENT IS BASED ON THE PROVIDER'S REQUEST FOR SEPARATE PAYMENT CONSIDERATION FOR IMPLANTABLE DEVICES.
- 859 – PLEASE PROVIDE A VALID NDC, CPT, HCPCS CODE, CHARGEMASTER CODE, AND/OR QUANTITY, ALONG WITH AN INVOICE IF APPLICABLE FOR APPROPRIATE REIMBURSEMENT \$0.00
- 989-101 – THIS BILL WAS REVIEWED IN ACCORDANCE WITH YOUR FEE FOR SERVICE CONTRACT WITH FIRST HEALTH.

Explanation of benefits dated February 9, 2010

- 670-007 – REIMBURSEMENT IS BASED ON THE PROVIDER'S REQUEST FOR SEPARATE PAYMENT CONSIDERATION FOR IMPLANTABLE DEVICES.
- 859 – PLEASE PROVIDE A VALID NDC, CPT, HCPCS CODE, CHARGEMASTER CODE, AND/OR QUANTITY, ALONG WITH AN INVOICE IF APPLICABLE FOR APPROPRIATE REIMBURSEMENT \$0.00
- 989-101 – THIS BILL WAS REVIEWED IN ACCORDANCE WITH YOUR FEE FOR SERVICE CONTRACT WITH FIRST HEALTH.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code 45 – “CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT”, and 989-101 – “THIS BILL WAS REVIEWED IN ACCORDANCE WITH YOUR FEE FOR SERVICE CONTRACT WITH FIRST HEALTH.” Review of the submitted information finds that the documentation does support a contract existed between the healthcare provider and the carrier. However, the effective date of the contract is December 1, 2009. The date of service in dispute is October 20, 2009 prior to the effective date of this contract. Consequently, the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines..
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was requested. Therefore, per §134.403(f)(1)(B), the facility specific

reimbursement amount including outlier payments is multiplied by 130 percent. Per §134.403(f)(2), when calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under §134.403(g). The facility's total billed charges for the separately reimbursed implantable items are \$98,860. Accordingly, the facility's total billed charges shall be reduced by this amount for the purpose of calculating any outlier payments below.

3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
 - Procedure code L8687 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code 63685 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. The provider billed this procedure code with 5 units; however, review of the submitted documentation finds that only 1 unit is supported. Therefore, only 1 unit can be considered for payment. These services are classified under APC 0222, which, per OPPS Addendum A, has a payment rate of \$15,566.65. This amount multiplied by 60% yields an unadjusted labor-related amount of \$9,339.99. This amount multiplied by the annual wage index for this facility of 0.9731 yields an adjusted labor-related amount of \$9,088.74. The non-labor related portion is 40% of the APC rate or \$6,226.66. The sum of the labor and non-labor related amounts is \$15,315.40. The cost of these services does not exceed the annual fixed-dollar threshold of \$1,800. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$15,315.40. This amount multiplied by 130% yields a MAR of \$19,910.02.
 - Procedure code 95972 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0692, which, per OPPS Addendum A, has a payment rate of \$109.24. This amount multiplied by 60% yields an unadjusted labor-related amount of \$65.54. This amount multiplied by the annual wage index for this facility of 0.9731 yields an adjusted labor-related amount of \$63.78. The non-labor related portion is 40% of the APC rate or \$43.70. The sum of the labor and non-labor related amounts is \$107.48. The cost of these services does not exceed the annual fixed-dollar threshold of \$1,800. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$107.48. This amount multiplied by 130% yields a MAR of \$139.72.
4. Additionally, the provider requested separate reimbursement of implantables. Per §134.403(g), "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or \$1,000 per billed item add-on, whichever is less, but not to exceed \$2,000 in add-on's per admission." Review of the submitted documentation finds that the separate implantables include:
 - "IMP MEDT ANTENNA" as identified in the itemized statement and labeled on the invoice as "ANTENNA 37092 EXT ULTRA" with a cost per unit of \$80.00;
 - "IMP MEDT PT PROGRAMMR" as identified in the itemized statement and labeled on the invoice as "PROG 37743 PATIENT ULTRA" with a cost per unit of \$1,071.00;
 - "IMP MEDT CHARGING SYSTEM" as identified in the itemized statement and labeled on the invoice as "PROG 37752 RECHARGE ULTRA" with a cost per unit of \$2,151.00;
 - "IMP MEDT 1X4 POCKET ADAPTER" as identified in the itemized statement and labeled on the invoice as "ADAPTOR 74001 1X4 POCKET" with a cost per unit of \$495.00;
 - "IMP MEDT GENERATR RESTOREULTRA" as identified in the itemized statement and labeled on the invoice as "INS 37712 R4STORE ULTRA" with a cost per unit of \$15,975.00.

The total net invoice amount (exclusive of rebates and discounts) is \$19,772.00. The total add-on amount of 10% or \$1,000 per billed item add-on, whichever is less, but not to exceed \$2,000 in add-on's per admission is \$1,379.70. The total recommended reimbursement amount for the implantable items is \$21,151.70.
5. The total allowable reimbursement for the services in dispute is \$41,201.44. This amount less the amount previously paid by the insurance carrier of \$21,793.70 leaves an amount due to the requestor of \$19,407.74. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$19,407.74.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$19,407.74, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

_____	_____	<u>June 20, 2013</u>
Signature	Medical Fee Dispute Resolution Officer	Date

_____	_____	<u>June 20, 2013</u>
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.